Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Division of Alcohol and Substance Abuse,
Juvenile Rehabilitation Administration, and
Medical Assistance Administration

Chemical Dependency

TITLE XIX CONTRACTORS
(WAC 388-805)
Outpatient Billing Instructions

October 2003

About this publication

This publication supersedes all previous Chemical Dependency Billing Instructions.

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Important Contacts

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

How do I request billing instructions?

Go to MAA's website:
http://maa.dshs.wa.gov

Write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I call if I have questions regarding…

Policy or reimbursement rates?

Division of Alcohol & Substance Abuse
PO Box 45330
Olympia, WA 98504-5330
(360) 438-8209

-or-

Juvenile Rehabilitation Administration
PO Box 45720
Olympia, WA 98504-5720
(360) 902-8105

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Go to:
http://maa.dshs.wa.gov/ecs

Definitions

This section contains definitions and acronyms used in these billing instructions.

Acute Detoxification Services – A method of withdrawing a patient from alcohol or other drugs where nursing services and medications are routinely administered under physician supervision to facilitate the patient's withdrawal. Services include medical screening of patients, medical detoxification of patients, counseling of patients regarding their illness to stimulate motivation to obtain further treatment, and referral of detoxified patients to other appropriate treatment programs. Acute Detoxification services shall include all services included in WAC 246-326-100 or its successor.

Alcohol Abuse - Use of alcohol in amounts hazardous to individual health or safety.

Alcoholism - A disease characterized by:

- A dependence on alcoholic beverages or the consumption of alcoholic beverages;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance;
- Physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Alcoholism and/or Alcohol Abuse Treatment (Outpatient) - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the untoward effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by a combination of alcohol education sessions, individual therapy, group therapy, and related activities provided to detoxified alcoholics and their families.

Approved Treatment Facility -A treatment facility, either public or private, for profit or nonprofit, approved by DSHS pursuant to WAC 388-805 and RCW 70.96A.

Assessment - The set of activities conducted on behalf of a new client, for the purpose of determining eligibility, evaluating treatment needs, and making necessary referrals and completing forms. The assessment includes all practices listed in applicable sections of WAC 388-805 or its successor.

For the purpose of determining eligibility for Chemical Dependency Disposition Alternative (CDDA), the set of activities will include completion of:

- The Adolescent Drug Abuse Diagnosis (ADAD);
- The "Kiddie" version of the Schedule of Affective Disorders and Schizophrenia (K-SADS); and
- American Society of Addiction medicine (ASAM) and WAC questionnaire forms.

Case Management – Services provided by a Chemical Dependency Professional (CDP) or CDP Trainee to clients assessed as needing treatment to assist clients in gaining access to needed medical, social, educational, and other services. Services include case planning, case consultation and referral, and other support services for the purpose of engaging and retaining or maintaining clients in treatment.

Chemical Dependency - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

Chemical Dependency Disposition Alternative (CDDA) – A sentencing option of chemically dependent youth offenders which allows judges to order community-based treatment in lieu of confinement. [RCW 13.40.165]

Chemical Dependency Professional (CDP) – A person certified as a chemical dependency professional by the Washington State Department of Health under Chapter 18.205 RCW.

Client - An applicant for, or recipient of, DSHS medical care programs.

Criminal Justice Treatment Account (CJTA) –A fund authorized by the state Legislature to provide community-based substance abuse treatment alternatives for offenders with an addiction or substance abuse problem against whom charges are filed by a prosecuting attorney in Washington State.

Division of Alcohol and Substance Abuse (DASA) – A division within DSHS responsible for providing alcohol and drug related services to help clients recover from alcoholism and drug addiction.

Department - The state Department of Social and Health Services. [WAC 388-500-0005]

Detoxification – Care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Drug Abuse - The use of a drug in amounts hazardous to a person's health or safety.

Drug Addiction - A disease characterized by:

- A dependency on psychoactive chemicals;
- Loss of control over the amount and circumstances of use;
- Symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued; and
- Impairment of health or disruption of social or economic functioning.

Drug Addiction and/or Drug Abuse Treatment - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities provided to detoxified addicts and their families.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – (Formerly referred to as the "Healthy Kids" program.) A program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

Expanded Chemical Dependency Assessment for Division of Children and Family Services (DCFS) - Comprehensive assessments of adults who are referred by DCFS staff that include:

- Chemical dependency diagnosis with a specific recommended chemical dependency treatment course that includes the recommended duration of chemical dependency treatment;
- A list of the assessment instruments/ tools used in the assessment process;
- Psychosocial history, including past drug/alcohol use financial problems, education, and legal issues;
- Information from collateral contacts that include friends, relatives, immediate and extended family members, and professional service providers who have had prior involvement with the client;
- Results of an initial urinalysis; and
- Prognosis for recovery.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Group Therapy - Planned therapeutic or counseling activity conducted by one or more certified CDPs to a group of three or more unrelated individuals and lasting at least 45 minutes. Acupuncture may be included as a group therapy activity.

Health Maintenance Organization (HMO) – An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis. [WAC 388-500-0005]

Healthy Options – See Managed Care.

Individual Therapy - A planned therapeutic or counseling activity provided to an eligible client by a certified CDP or group of certified CDPs. Individual therapy includes treatment provided to a family group consisting of a primary client and one or more significant others, or treatment provided to a couple who are married, contemplating marriage, or living together. Individual therapy may be provided to a family group without the primary client present.

Initial Screen – Component of the DCFS expanded assessment process in which the chemical dependency agency:

- Begins the assessment process;
- Completes the initial-short assessment and the urinalysis; and
- The client fails to return to complete the full assessment.

Intake Processing- The set of activities conducted on behalf of a new client. Intake processing includes all practices listed in applicable sections of WAC 388-805 or its successor. Intake processing includes obtaining a written recommendation for chemical dependency treatment services from a referring licensed health care practitioner.

Intensive Youth Case Management – Services provided by a certified CDP acting as a case manager to a youth under the CDDA program who is in need of, or currently using, chemical dependency treatment services. The purpose is to assist juvenile offenders in the JRA system to obtain and efficiently utilize necessary medical, social, educational and other services to improve treatment outcomes. Minimum standards of performance will be issued by JRA.

Juvenile Rehabilitation Administration (JRA)- An administration within DSHS responsible for providing a continuum of preventative, rehabilitation, residential, and supervisory programs for juvenile offenders and their families.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.

[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Opiate Substitution Treatment - Services provided to clients in accordance with WAC 388-805or its successor. Services are consistent with all state and federal requirements and good treatment practices and must include, as a minimum, the following services: physical examination upon admission; urinalysis testing one time per month; initial treatment plan and treatment plan review one time per month; vocational rehabilitation services as needed (may be by referral); dose preparation and dose dispensing; detoxification if and when needed; patient case management; individual and/or group counseling one time per month; one session of family planning; HIV screening, counseling, and testing referral; and psychological screening.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

a) First and middle initials (or a dash [-] must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Pregnant and Postpartum Women (PPW) Assessment – Assessment provided to an eligible woman who is pregnant or postpartum. The postpartum period covers the 60 days after delivery and any remainder of the month in which the 60th day falls.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Sub-Acute Detoxification Services – A method of withdrawing a patient from alcohol or other drugs utilizing primarily social interaction between patients and staff within a supportive environment designed to facilitate safety for patients during recovery from the effects of withdrawal from alcohol or other drugs. Withdrawal medications are ordered by a physician and self-administered by the patients, not staff. Services include screening of patients, non-medical detoxification of patients, counseling of patients regarding their illness to stimulate motivation to obtain further treatment, and referral of detoxified patients to other appropriate treatment programs. Sub-Acute Detoxification services shall include all services included in WAC 246-326-100 or its successor.

Temporary Assistance For Needy Families (TANF) - The federal welfare program established in 1996 that combined the Aid to Families with Dependent Children (AFDC) (cash aid) and the JOBS Opportunities and Basic Skills (welfare-to-work) programs into one program funded by one federal block grant.

TANF Client - Clients eligible for TANF who are receiving assessment and treatment services.

Third Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Tuberculosis (TB) Testing - Administration and reading of the Intradermal Skin Test, to screen for tuberculosis, by: licensed practitioners within the scope of their practice as defined by state law or by DOH WACs; or as provided by a tuberculosis community health worker approved by the DOH.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Youth - Individuals over 9 and under 21 years of age.

Chemical Dependency

Who should use these billing instructions?

These billing instructions should be used by **outpatient chemical dependency treatment centers** contracted through the Division of Alcohol and Substance Abuse (DASA) and Juvenile Rehabilitation Administration (JRA). These billing instructions should also be used by freestanding detoxification centers contracted through the DASA.

DASA is responsible for establishing an alcoholism and drug abuse prevention program and for providing a continuum of alcoholism and drug abuse treatment services to help persons recover from alcoholism and drug addiction. DASA does this by assuring quality of treatment services in the state, contracting with counties and private organizations to provide treatment, and establishing prevention programs.

Use these billing instructions and fees in conjunction with your contract on file with the Department of Social and Health Services, Division of Alcohol and Substance Abuse. ***Contract stipulations always take precedence over billing instructions.***

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Client Eligibility

Who is eligible?

Only those clients who present a Medical Assistance IDentification Card with the following identifiers **are eligible** for services under the Chemical Dependency Program:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	Children's Health Insurance Program
CNP – QMB	Categorically Needy Program – Qualified Medicare Beneficiary
LCP-MNP	Limited Casualty Program - Medically Needy Program
MNP – QMB	Medically Needy Program – Qualified Medicare Beneficiary

The client's Medical Assistance ID Card must show eligibility for the date(s) services are rendered.

Examples of who is not eligible

Clients who present a Medical Assistance ID Card with one of the following identifiers are **not eligible** for treatment services under the Chemical Dependency Program. **These are only examples and should not be considered an exhaustive list.**

Medical Program Identifier	Medical Program Name
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Only
Detox Only	DETOX
Family Planning Only	Family Planning
GA-U No Out of State Care	General Assistance - Unemployable
QMB Medicare Only	Qualified Medicare Beneficiary – Medicare Only
TAKE CHARGE	TAKE CHARGE Family Planning Program

Are clients who are enrolled in an MAA managed care plan eligible for services under the Chemical Dependency program?

Yes! Clients who are enrolled in an MAA managed care plan are eligible for Chemical Dependency services outside their plan. MAA reimburses chemical dependency services through fee-for-service. **No referral is required from the managed care plan when services are provided by DASA providers.**

Clients who are enrolled in an MAA managed care plan will have an "HMO" identifier in the HMO column on their Medical Assistance ID cards.

Coverage/Limitations

SERVICE	LIMITATION
Acute Detoxification Services	• Covered once per day, per client. • Covered up to a maximum of 3 consecutive days for alcohol detoxification. • Covered up to a maximum of 5 consecutive days for drug detoxification.
Case Management	• Covered up to a maximum of 5 hours per calendar month per client. • One unit equals 15 minutes. • Must be provided by a certified CDP or CDP Trainee. • Cannot be billed for the following activities: outreach, time spent reviewing a certified CDP Trainee's file notes, internal staffings, writing treatment compliance notes and progress reports to the court, interactions with probation officers, and court reporting.
Chemical Dependency Assessment	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services by the same agency.
Initial Screen	• Covered once per client. • Do not bill until 60 days after the screen was completed and the sample collected.
Expanded Chemical Dependency Assessment	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services by the same agency. • If an Initial Screen has been billed for a Division of Children & Family Services (DCFS) referred client, the billing for the expanded assessment must be reduced by the amount of the initial screen, as the Initial Screen is a component of the expanded assessment for a DCFS client.
Intake Processing	• Covered for new and returning clients only if the date of intake occurs more than 30 days from the last date of any covered outpatient treatment services, except for an assessment, by the same agency.

SERVICE	LIMITATION
Individual Therapy - DASA	• Covered up to a maximum of 3 hours per day, per client. • Individual therapy is covered only when provided for a minimum of 15 minutes. • One unit equals 15 minutes. After the first 15 minutes, each additional unit is billed after it is begun rather than after it is finished (ex: when a session lasts 17 minutes it is billed as two units). **Note:** When family members attend an individual session either in lieu of, or along with, the primary client, the session may be claimed only once regardless of the number of family members present.
Individual Therapy Full Visit- JRA	• One unit covered per day, per client. • One unit equals one hour. • Individual therapy is covered only when provided for a minimum of one hour. **Note:** When family members attend an individual session either in lieu of, or along with, the primary client, the session may be claimed only once regardless of the number of family members present.
Individual Therapy Brief Visit - JRA	• Covered once per day, per client. • A session of 15 minutes to 45 minutes in duration constitutes a brief visit.
Intensive Youth Case Management - JRA	• Covered once per calendar month for clients under 21 years of age. • Services may only be performed for youth in the CDDA program by the providers identified by JRA.
Group Therapy	• Covered up to a maximum of 3 hours per day. • Claims for group therapy may be made only for those eligible clients or their families within the group. • One unit equals 15 minutes. • Group therapy is covered only when provided for a minimum of 45 minutes (3 units) up to a maximum of 3 hours (12 units) per client, per day. • Acupuncture is considered a group therapy procedure for the primary client. **Note:** When family members attend a group therapy session either in lieu of, or along with, the primary client, the session may be claimed only once regardless of the number of family members present.
Opiate Substitution Treatment	• If provided, covered once per day while a client is in treatment.

SERVICE	LIMITATION
Sub-Acute Detoxification Services	• Covered once per day, per client. • Covered up to a maximum of 3 consecutive days for alcohol detoxification. • Covered up to a maximum of 5 consecutive days for drug detoxification.
Tuberculosis (TB) Testing	• TB testing is a covered service when provided by a licensed practitioner within the scope of his/her practice as defined by state law or by the Department of Health WACs, or as provided by a tuberculosis community health worker approved by the Department of Health.
Urinalysis-Drug Screening	• Urinalysis-drug screenings are covered only for methadone patients and pregnant women. • A urinalysis drug screening must be billed through DASA's contracted provider. **Call DASA at (360) 407-1109 for more information.**

<u>Do not bill</u> for case management or intensive case management under the following situations:

- If a pregnant woman is receiving maternity case management services under MAA's First Steps Program;
- If a person is receiving HIV/AIDS case management services through the Department of Health (DOH);
- If a youth is on parole in a non-residential setting and under the Juvenile Rehabilitation Administration's (JRA) supervision. Youth served under the Chemical Dependency Disposition Alternative (CDDA) program are <u>not</u> under JRA supervision;
- If a youth is in foster care through the Division of Children and Family Services (DCFS); and
- If a person is receiving case management services through any other funding source from any other Department system (i.e. person enrolled in Mental Health with a Primary Health Provider).

(Billing for case management under these situations is prohibited because federal financial participation is being collected by MAA, DOH, DCFS, JRA, or the Division of Mental Health for these clients.)

Note: Services provided to children under 10 years of age must be pre-approved by the DASA contract manager.

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DIVISION OF ALCOHOL AND SUBSTANCE ABUSE
ALCOHOL AND DRUG TREATMENT
OUTPATIENT SERVICE REIMBURSEMENT SCHEDULE

For services provided on and after October 1, 2003

Procedure Codes - Modifier		HCPCS/ CPT Code Description	Service	Fee-for-Service Maximum Rates
General	CJTA* Funded			
H0003-HF		Alcohol and/or drug screening	DCFS Initial Screening	$18.33
H0001-TG		Alcohol and/or drug assessment, complex/high tech level of care	DCFS Expanded Chemical Dependency Assessment	$177.69
H0001-HF	H0001-HZ	Alcohol and/or drug assessment, substance abuse program	Chemical Dependency Assessment	$91.22
H0001-HD		Alcohol and/or drug assessment, pregnant/parenting women's program	Pregnant & Postpartum Women Assessment	$91.22
H0002-HF	H0002-HZ	Screening for admission to treatment program	Intake Processing	$13.38
96154-HF	96154-HZ	Health and behavior intervention, family with patient present	Individual Therapy with Client Present	$14.21 per 15 minutes
96155-HF	96155-HZ	Health and behavior intervention, family without patient present	Individual Therapy Without Client Present	$14.21 per 15 minutes
96153-HF	96153-HZ	Health and behavior intervention, group	Group Therapy	$4.47 per 15 minutes
T1017-HF	T1017-HZ	Targeted case management, each 15 minutes	Case Management	$7.50 per 15 minutes
H0020-HF	H0020-HZ	Methadone administration and/or service	Opiate Substitution Treatment	$10.36 per day
86580	86580	Tuberculosis test intradermal	Tuberculosis Testing	$5.92

***CJTA = Criminal Justice Treatment Account**

JUVENILE REHABILITATION ADMINISTRATION
ALCOHOL AND DRUG TREATMENT

OUTPATIENT SERVICE REIMBURSEMENT SCHEDULE

For services provided on and after October 1, 2003

Procedure Codes - Modifier				
CDDA* Locally Sanctioned	**CDDA Committable**	**HCPCS/CPT Code Description**	**Service**	**Fee-for-Service Maximum Rates**
H0001-U7	H0001-H9	Alcohol/or drug assessment; Substance Abuse Program	Chemical Dependency Assessment	$91.22
H0002-U7	H0002-H9	Screening for admission to treatment program	Intake Processing	$13.38
H2035-U7	H2035-H9	Alcohol and/or drug treatment program, per hour	Individual Therapy – Full Visit (Minimum 1 hour)	$56.85
H0047-U7	H0047-H9	Alcohol and/or drug abuse services, not otherwise specified	Individual Therapy – Brief Visit (15-45 minutes for individual and/or family	$30.35
96153-U7	96153-H9	Health and behavior intervention, group	Group Therapy	$4.47 per 15 minutes
H0006-U7	H0006-H9	Health and behavior intervention, group	Intensive Youth Case Management	$194.35 per month
86580	86580	Tuberculosis test intradermal	Tuberculosis Testing	$5.92

Note: Billing for these services is restricted to those providers who are contracted to provide services to CDDA youth through a JRA contract.

***CDDA=Chemical Dependency Disposition Alternative.**

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE
ALCOHOL AND DRUG DETOXIFICATION SERVICES

REIMBURSEMENT SCHEDULE

For services provided on and after October 1, 2003

Procedure Code/Modifier		HCPCS/CPT Code Description	Service	Fee-for-Service Maximum Rates
General	CJTA* Funded			
H0011-HF	H0011-HZ	Alcohol/or drug services; acute detoxification	Acute Detoxification Services	$148.36 per day
H0010-HF	H0010-HZ	Alcohol/or drug services; sub acute detoxification	Sub-Acute Detoxification Services	$108.36 per day
H2036-HF	H2036-HZ	Alcohol/or drug treatment program, per diem	Room and Board	$11.64 per day

Note: Billing for these services is restricted to those providers who are currently certified through DASA and contracted with the counties to provide these services.

***CJTA = Criminal Justice Treatment Account**

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in the appropriate MAA billing instruction.

- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time periods listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical Identification Card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB; and
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial.
- If you are rebilling electronically, list the claim number (ICN) of the previous denial.

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/ or by calling the Coordination of Benefits Section at 1-800-562-6136.

What must I keep in the client's file?

[WAC 388-503-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs. [WAC 388-502-0020(2)]

Correct Coding Initiative

MAA is evaluating and implementing Medicare's Correct Coding Initiative (CCI) policy. This policy was created by the Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methodologies. CCI will assist MAA in controlling improper coding that may lead to inappropriate payment. MAA will base coding policies on the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national professional societies, the analysis and review of standard medical and surgical practices, and review of current coding practices. These correct coding policies do not necessarily supercede any other specific MAA coding, coverage, or payment policies, unless specifically stated.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1a. **Insured's I.D. NO.**: **Required**. Enter the MAA Patient (client) Identification Code (PIC) alphanumeric code exactly as shown on the client's DSHS Medical ID card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: **Required**. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: **Required**. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.
9B. Enter the other insured's date of birth.
9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**:. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.* If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes.* If **11d** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17A. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form. Total each claim separately.**

24A. **Date(s) of Service**: **Required**. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403).

Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. **Place of Service**: **Required**. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
11	Office or center
08	Tribal 638 provider facility

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required**. Enter the appropriate procedure code with a modifier for the services being billed.

24E. **Diagnosis Code**: Enter **303.9** (for alcohol dependency) **or** **304.9** (for drug dependency).

For youth and pregnant & postpartum women, the following diagnosis codes may be used to distinguish abuse: **305.0** (for alcohol abuse) **or** **305.9** (for drug abuse).

A diagnosis code is required on each line billed. For assessment purposes, the diagnosis code does not reflect the outcome of the assessment or the diagnosis of the client.

24F. **$ Charges**: **Required**. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required**. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number.*

28. **Total Charge**: **Required**. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: **Required**. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: **Required**. Put the name, address, and telephone # on all claim forms.

GRP#: Required. Enter the seven-digit number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

CHEMICAL DEPENDENCY

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PH061262LUCASA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LUCAS PETER H

3. PATIENT'S BIRTH DATE MM DD YY: 06 12 62 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 600 BARTON STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	03	03	10	03	03	11		H0002	HF	304.9	1500	1				
2	10	03	03	10	03	03	11		96153	HF	304.9	7038	4				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 8538

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 8538

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

CITY OUTPATIENT SRVCS
2612 MAIN STREET
ANYTOWN WA 98000 (360) 555-0303

PIN# GRP# 19999999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500